Attachment Twenty-six Maternity Care Program Operational Manual Effective 1.1.16

Maternity Care Program Intake Form



| Recipient Name |
|---|
| Date of Birth |
| Address |
| County of Residence |
| |
| Social Security Number |
| Medicaid Number |
| If no assistance is required with Medicaid application, provide to eligibility DHCP selected |
| Notified DHCP & 1st appointment obtained |
| Risk Status assigned |